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ABSTRACT

This paper describes some of the complex difficulties faced by therapists treating incestuous families. The many levels of transference and countertransference are described, pointing to one reason for treatment complexity. It is claimed that the therapist's emotional reactions can be understood as a parallel to the internal and interpersonal dynamics in the family, and utilized as a tool in treatment. Specific countertransference difficulties which are addressed include feelings of hate towards the incest perpetrator, discomfort in discussing sexuality, victim/victimizer patterns, and boundary violations in treatment. The histories of sexual abuse of the perpetrator and the spouse in incestuous families is reviewed. Therapeutic boundaries are described. Case presentations are utilized to illustrate these ideas. Literature on relevant topics is cited. It is noted that whatever form countertransference takes, it is essential that the family therapist be able to use the feelings to understand parallel experiences in the family as a whole and in the individual members' internal worlds and that feeling perplexed in treatment is often a necessary step for the therapist in digesting the experience in order to use it therapeutically. It is concluded that only when therapists are able to tolerate the difficult feelings can they expect the incestuous family to have the courage to set out on its own painful journey toward change. (Contains 19 references.) (Author/ABL)

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ABSTRACT

Transference and Countertransference Reactions in Therapy with Incestuous Families

Wendy Greenspun, Ph.D.

Paper presented at the Centennial Convention of the American Psychological Association, Washington, D.C., August 1992.

This paper describes some of the complex difficulties faced by therapists treating incestuous families. Only by adding a psychoanalytic understanding of transference and countertransference to a family systems theoretical approach can productive work occur. The many levels of transference and countertransference are described, pointing to one reason for treatment complexity. The therapist's emotional reactions can be understood as a parallel to the internal and interpersonal dynamics in the family, and utilized as a tool in treatment. Specific countertransference difficulties which are addressed include feelings of hate toward the incest perpetrator, discomfort in discussing sexuality, victim/victimizer patterns, and boundary violations in treatment. Case presentations are utilized to illustrate these ideas.

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Transference and Countertransference Reactions in Therapy with Incestuous Families

Wendy Greenspun, Ph.D.

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Writing this paper was one of the most torturous experiences I have had with a professional presentation. I had set aside several weekends over the summer and tried to work. A myriad of ideas went around in my head, only to be replaced with more and completely different angles and approaches. The deadline was nearing; I could not figure out why I experienced such difficulty. Assuming only that this was a ridiculously complex topic to cover in a short presentation, I narrowed my focus to a few key issues in transference and countertransference with the incestuous family. The result was a paper with which I was only vaguely satisfied. Something was missing.

I asked a colleague for his feedback on what I had written. He immediately confirmed my opinion, and helped to pinpoint the problem. "It is so theoretical. It's as if you've removed all the feelings," he said. With characteristic intellectualization, I had defended against experiencing the difficult emotions that were elicited by my memories of treating these cases.

It was then obvious that a parallel process was at work. Trying to write a paper on this topic is much like trying to treat the incestuous family-- it can be overwhelming, confusing, stirs up too many feelings, and often requires outside

supervision or consultation in order to manage. And yet, utilizing all aspects of countertransference reactions is key to truly productive work.

This paper will describe some of the difficulties faced in treating the family with incest. The therapist's countertransference as a parallel to family dynamics and transference reactions will be described utilizing both psychoanalytic and family systems concepts.

Just what is so difficult about transference and countertransference experiences with the incestuous family? First, it is important to understand the many levels at which these experiences occur in family treatment. Each individual in the family sustains his or her own transference toward the therapist as well as toward each other. The therapist in turn has a corresponding countertransference response to each individual family member. The family as a whole also demonstrates a shared reaction to the therapist, and the therapist likewise has a countertransferential reply to the group as a whole (Scharff, 1989). The sheer number of possible feelings at a given time can be overwhelming. Marshall (1983) underscored this idea when he stated that, "the complexity of the countertransference situation is increased probably exponentially as the number of adjunctive relationships is increased" (p.433.)

Family systems therapists have traditionally dealt with the complexity of feelings in a session by focusing primarily on

family process and structure, rather than individual reactions or emotions, including countertransference. Any therapist who has stepped foot into an office with a chaotic family can fully appreciate this ability to take a "meta" view of what is occurring, in order to prevent being swept into the family affective experience. The systemic approach provides an essential tool for managing the multiple demands and levels of experience.

In treating the incestuous family, it is a much more arduous task to focus only on systemic issues and to therefore fend off unwieldy countertransference reactions. Partly this is due to the nature of the incestuous act itself, which cannot be construed in purely systemic terms. Dell (1989) and Goldner, Penn, Sheinberg and Walker (1990) described the inherent inability for systems theory alone to account for acts of violence between individuals with unequal power. While traditional family therapy approaches would emphasize the function served for the family by a particular behavior, and the collusion of all family members in its maintenance, violence and incest cannot be interpreted in this manner without implicating the victim in his or her own abuse. In addition, the necessary acknowledgement of the perpetrator's heinous behavior makes it difficult for the family therapist to maintain a solely systemic approach, since each family member does not play an equal role in the family drama. Without the usual, clear outline of systemic

objectivity, the floodgate to countertransference reactions in family therapy can open.

Let me illustrate this point with a clinical example. The Walters family consisted of mother, father, and their 18 year old daughter, Laura who sought therapy for what sounded like family problems related to developmental issues. Laura and her father were having horrible arguments, which had gotten worse as the daughter began to develop a more independent existence. Mrs. Walters was also concerned that her daughter was having trouble with boys, which she felt related primarily to Laura's conflictual relationship with Mr. Walters. Laura denied any physical or sexual abuse experiences.

After meeting with the family, I initially hypothesised that there was a clear alliance between the mother and daughter, and the father was the isolated outsider. The parents' marital conflicts were not voiced directly (although clearly present), but instead were enacted by Laura rather than the mother, during fights with the father. According to family systems theory, this suggested that Laura had been triangulated into the parents' marriage; that is, due to the instability of the marital relationship, a third party was brought in to help diffuse the marital tensions (Bowen, 1976). My plan of treatment was to help the daughter stay out of the triangulated position, and for the parents to begin addressing each other more directly. This represented a clear, systemic treatment plan which helped me stay

focused and relatively unruffled in the face of sometimes vehement verbal battles in the family.

After several weeks of treatment, Mrs. Walters came in individually to drop off an insurance form. After a brief, casual discussion, she suddenly revealed several confidences. First, she said that she had been sexually abused by her father when she was a child. Then she told me her most painful secret: she herself had sexually abused her daughter throughout Laura's first five years of life. Mrs. Walters had never discussed these issues with either her daughter or husband, and Laura seemed to have no memory of the incest.

My reaction to the disclosure was quite strong. Although intellectually I knew that my goal would be for her to share the secrets with the family, I felt extremely anxious about the idea, thinking it would disrupt the family equilibrium and possibly harm Laura in some way. More significantly, I was furious at Mrs. Walters for "dumping" this secret on me. I felt paralyzed by my feelings, and dreaded seeing the family again. No longer on my clear, systems-oriented course, my countertransference reactions emerged and seemed overwhelming.

Any incidence of countertransference can be utilized to understand the underlying dynamics of a case. It is essential that the therapist first tolerate the stirred-up emotions and experience them fully in order to understand the parallel dynamic in the individual or family. Only by adding this

psychoanalytically- informed knowledge of countertransference to a systemic approach can the family therapist adequately treat the incestuous family. Some specific countertransference reactions in incest treatment will now be described.

Winicott's crucial paper, "Hate in the Countertransference" (1949), points to one significant problem for the therapist treating the incestuous family. Not only is it difficult theoretically to maintain a systemic stance when faced with an act of abuse in the family, but more significantly, the hate engendered in the therapist by the perpetrator's actions makes it extremely difficult to become empathic toward this victimizer. This creates quite a dilemma for the family therapist, who needs to ally with each family member in order to conduct the treatment.

This kind of countertransference hate was evident when I visited a prominent family therapy institute's incest treatment program. The senior clinician who worked with a group of perpetrator fathers explained to me that he could no longer observe the group for the victimized daughters, because to hear the daughters' stories made him hate the men too much to work effectively with them. In treating the family as a whole, it is not possible to isolate oneself from hearing the horrors of the victim's tale, and the therapist may instead utilize a variety of defenses in order to tolerate this therapeutic dilemma. These defenses may reflect the therapist's characteristic protective

mechanisms (such as my intellectualization in trying to write this paper), as well as mirroring aspects of the family's defensive pattern.

One common defense utilized by therapists faced with the perpetrator's violations is displacement. I can think of many instances of treating father-daughter incest where I saw the father as a sad, passive, pathetic man, for whom I felt sorry, and the mother as the "real" criminal for not protecting her daughter. While anger at such a mother may be real in and of itself, it can represent in part a displacement of intolerable feelings toward the perpetrator for his abusive behavior. Through this countertransference experience, the therapist can easily understand the victim's rage at her mother, which may also be partially fueled by displacement of anger toward the father.

The therapist's misguided anger may also signal a parallel displacement occurring in the family group transference. It is not uncommon for the incestuous family to show extreme resistance to treatment, and to direct their rage at the therapist, while denying the severity or impact of the perpetrator's abusive acts. This represents the family's displacement of anger from the perpetrator onto the therapist (Solin, 1986.) For family members to truly accept the horrible nature of the perpetrator's abuse would contradict feelings of love and loyalty toward an important family member. Certainly if the clinician can recognize how difficult it is personally to hate the perpetrator yet still

remain empathic toward him, the family's parallel dilemma can be easily comprehended. When the family is helped to tolerate these contradictory emotions, the complexity of the abuse situation can be more fully examined.

Another difficult countertransference arena relates to the topic of sexuality. While incest, like rape, is generally considered an issue of power and assault more than a sexually-motivated act, the family therapist still needs information regarding the sexual relationship of the marital couple, and must also hear about the sexual abuse itself. Many of us are not comfortable discussing the subject of sexuality in detail, particularly if it involves perversions of any kind, so considerable anxiety may be evoked in the process. In addition, the family's discomfort with sexuality may contribute to the therapist's anxiety in exploring this topic.

An even more disturbing aspect of countertransference related to sexuality is the therapist's sexual arousal. Therapists treating survivors of incest at times report feeling sexually aroused by their victimized patients, which can make the therapist quite uncomfortable. Yet these experiences of arousal are essential in understanding certain aspects of a family member's internal world.

I worked with a pedophile who would often go into detail about pornographic movies he had seen. Instead of the disgust I expected to experience, I found myself interested in hearing

more, and even excited by some of his descriptions. My own reactions disgusted me; I felt like a sexual deviant. After consulting with a trusted colleague, we were able to surmise that this patient, who had been overstimulated sexually by his mother, was inducing in me what Racker (1968) called a "concordant identification." In such an identification, the projection of certain split-off parts of the self results in the therapist experiencing what the patient felt at some point in time. In the case just described, my patient's fanatically religious mother had told him that sexual feelings were evil, such that his own sexual arousal by her left him feeling disgusted and deviant. Understanding that I was experiencing what the patient had often felt allowed me to explore the complexity of his feelings in greater depth. The induced countertransference was the key to this understanding.

Projective identification can explain a variety of these induced countertransference responses in working with the incestuous family. Calof (1991) describes how members of incestuous families project a variety of unacceptable, dissociated internal family objects into one another in an attempt to preserve the positive aspects of family life. A therapist who enters the family's world may similarly become a target for these split-off internal objects. Let me illustrate with an example.

The McCloskys were a rural, white family who were court-mandated for family treatment after the daughter, Jennifer, revealed three years of sexual abuse by her father. The father was removed from the home, but was willing to attend treatment with the family in order to possibly reunite with them in the future. All three members of the family acknowledged that the incest had taken place, but minimized the seriousness of its effects. Any questions on my part were met with vague answers or hostile defensiveness. Their only problem seemed to be my entrance into their lives.

My countertransference response alternated between feeling like a sadistic witch who was forcing them into dangerous territory, to believing I was extremely helpless, weak and ineffectual. At either extreme I questioned my ability to do therapy. After being stuck in these reactions for several weeks, I realized that the family seemed to be feeling very little, while I walked around like a nervous wreck after our meetings. When the therapist is reacting more than the patients, this may indicate projective identification at work.

By analyzing my feelings, I gained a greater understanding of the intolerable internal objects in the McClosky family. Inherent in my countertransference experience were the alternating victim and victimizer parts which had been transported out of the family members' conscious experience. Being sadistic paralleled the role of victimizer, which no one in

the family, including the perpetrator, wanted to directly acknowlege. Complimentary to the induced victimizer feelings, I felt helpless and weak, pointing to the projectively identified victim role.

From the pervasiveness of my induced feelings, I hypothesized that I was taking on more than one person's projections. Studies show that in most incest families, the perpetrator as well as the spouse often have their own childhood history of physical or sexual abuse (Burkett, 1991; Cavanaugh-Johnson, 1988; Criville, 1990; Finkelhor,1978; Finkelhor & Williams' study, cited in Vanderbilt, 1992; Swanson & Biaggio, 1985). Both the experience of victimization and the complimentary victimizer part exist in each abused person's internal object world, and may be kept alive by being projected outward, then interacted with. In a marriage between individuals who each have a history of abuse, the victim and victimizer role may be played out between the husband and wife. When there is excess stress on the marital system, the child who becomes incestuously violated may be triangulated into the marriage and becomes the container for the victim role.

When the family system is further stressed by the disclosure of the abuse, the therapist may similarly become the receptacle for intolerable internal objects. The incest perpetrator seems to identify more readily with the aggressor and needs to get rid of the victimized part, while the spouse and the incest victim

may transport their internal aggressor parts outward (Calof, 1991). In the transference, then, the therapist, becomes either the abused or the abuser. With this idea in mind, I was able to begin exploring with each of the McCloskys their feelings toward me. Once more trust was established, I could ask the parents about their own histories of victimization.

The last countertransference issue I will discuss relates to the issue of boundaries. Minuchin (1974) described family boundaries as the "rules defining who participates and how" (p.53). Boundaries define what is inside a system or subsystem and what is outside. Some boundaries need to be stronger than others, such as those between parents and children, and certain information should be allowed to permeate a boundary, while other information cannot. These barriers between one system and another allow for feelings of safety within the family.

In doing treatment, certain therapeutic boundaries also exist. As therapists, we know that our clinical work is bounded by the treatment frame (such as a regular time and place to meet with patients), and by the rules of confidentiality established by our profession. For the family therapist working with incest cases, these expected boundaries at times may not exist, which in itself can elicit considerable countertransference.

Needing to report cases of sexual abuse to the proper authorities may represent one such therapeutic boundary violation, since reporting allows outsiders into the privileged

relationship of therapy. Although it is essential that reporting take place in order to assure the safety of children, therapists often describe extensive doubts and negative reactions in having to report (Kalichman, Craig, and Follingstad, 1990). Fears of destroying the therapeutic alliance with the family, placing the family in the hands of an allegedly incompetent protective services system, and facing the potential for court appearances all contribute to clinician anxiety regarding the need to report abuse cases.

Once an incest case is reported, therapeutic boundary violations continue to take place. Ongoing contact with the legal and protective services systems may disrupt a therapist's sense of control over the treatment, and the excessive demands in such cases can lead to significant resentment about needing to work beyond the time frame of sessions. A clinical illustration of boundary- related countertransference follows.

My treatment of the Naylor family began after the father admitted to fondling his children's genitals, and the family was court-ordered into therapy. Mr. and Mrs. Naylor, and their two children, Dawn and Eric, came reluctantly to treatment. Both children had been sent to live with their maternal grandmother. No one in the family felt that therapy was necessary, and they angrily let me know how much they distrusted me.

In addition to frustration with their angry resistance, which can be understood in part as displacement of anger toward

the father, my greatest countertransference response came from trying to work with the protective services worker assigned to the Naylor case. She called me frequently, inquired about progess before I had even sufficiently engaged the family, and asked for written reports more frequently than I thought necessary. In addition, I began to question whether she had overreacted to the severity of the abuse situation itself, even though I had information to the contrary.

My intense reaction to this worker seemed puzzling. Usually I had found these workers overworked and unavailable, yet this woman was interested and involved. Objectively I could recognize that she cared a great deal about the case, yet I experienced her concern as intrusiveness. Somehow, I felt, she was entering into the treatment when I did not need her, and demanding too much of me.

The meaning of my countertransference became apparent when I noticed that my response to the protective services worker closely resembled the Naylor family's reaction to me. Unused to the "helpfulness" of the worker, I felt my therapeutic boundaries being violated. I surmised that a parallel boundary violation existed for the family, who experienced my caring and concern as intrusion, and my seriousness about the abuse as an overreaction.

The incestuous family is typically characterized by an extremely rigid boundary with the outside world, and overly-permeable boundaries between family members (Burkett, 1991).

Once the incest is disclosed, the usually protective external boundary is opened up to a variety of outsiders, disrupting the family equilibrium. Any therapist entering treatment at that point becomes one such boundary disruptor, such that the initial treatment problem to address is the family's sense of violation (Tyler and Brassard, 1984; Trepper and Barrett, 1989.) With the Naylors, I began to address the infringement of privacy in having to come to therapy, and we could explore what privacy had meant to them in terms of protection. Discussing violation of the family boundary can then lead directly to the topic of personal boundary violation in the incest. Parallel to this work with the family, the therapist can facilitate a clear boundary with regard to each adjunctive service worker which allows all involved in a case to share information, yet know their specific role. This models appropriate boundary establishment for the family.

In whatever form countertransference takes, it is essential that the family therapist be able to use the feelings to understand parallel experiences in the family as a whole and in the individual members' internal worlds. Feeling perplexed in treatment, much like my feeling lost in initially writing this paper, is often a necessary step in digesting the experience in order to use it therapeutically. Self- analysis or consulting with a supervisor or colleague can then be utilized to help withstand and make sense of the difficult emotions that have been aroused. Only when therapists are able to tolerate the difficult

feelings can we expect the incestuous family to have the courage to set out on their own painful journey toward change.

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